AMENDED IN SENATE MARCH 28, 2006

SENATE BILL No. 1823

Introduced by Senator Dunn

February 24, 2006

An act to amend ~~Section 1371.35 of~~ *and repeal Section 1371.37 of, and to add Sections 1348.1 and 1348.2 to,* the Health and Safety Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

SB 1823, as amended, Dunn. Health care service plans: claim reimbursements.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. The ~~act requires~~ *Knox-Keene Act prohibits* a health care service plan ~~to reimburse a claimant for an uncontested, complete claim within a specified period of time and assesses a penalty or interest, which the plan must automatically pay to the claimant, for its failure to reimburse the claim within the designated time frame~~ *from engaging in an unfair payment pattern, as defined, and authorizes the department to investigate whether a plan has engaged in such a practice and to impose a penalty for that conduct. The Knox-Keene Act requires the department to make available information regarding actions it has taken pursuant to these provisions.*

This bill would ~~assess an additional penalty of $45 against a health care service plan that fails to automatically pay a claimant the initial penalty or interest for failure to timely reimburse its claim. The bill would authorize the claimant to bill the plan for this additional penalty~~

~~amount in addition to any other amounts owed~~ *additionally prohibit a medical group having responsibility to pay a provider claim from engaging in an unfair payment pattern. The bill would require the department to investigate, in specified circumstances, complaints by noncontracting physicians and surgeons who furnished emergency services and care and would prohibit, on and after July 1, 2007, the department from exempting a plan or medical group from an unfair payment pattern violation by approving a proprietary database. The bill would require the department to develop a "fast-track" process for resolving a payment practice it previously found unfair and to assess a plan or medical group that engaged in that same practice a fine 3 times the amount by which the provider was underpaid. The bill would also require a plan or medical group to make restitution automatically, except as specified, to a provider for the amount by which the provider was underpaid and would specify that any monetary penalty assessed against a plan or medical group equal to at least that amount. The bill would require the department to report to the Legislature any investigations of unfair payment patterns that were not completed within 6 months of the complaint's submission and would specify information the department is required to provide the public and providers concerning complaints of unfair payment patterns*.

Because the bill would specify ~~an~~ additional ~~requirement~~ *requirements* under the Knox-Keene Act, the willful violation of which would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

~~SECTION 1. Section 1371.35 of the Health and Safety Code is amended to read:~~

~~1371.35. (a) A health care service plan, including a specialized health care service plan, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the complete claim by the health care service plan. However, a plan may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial. A plan may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim if the plan pays those charges specified in subdivision (b).~~

~~(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt, the plan shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor. If the plan fails to automatically include that sum or the interest due in its payment to the claimant, the plan shall pay the claimant an additional forty-five dollars ($45) penalty. The claimant may bill the plan for this additional penalty amount in addition to any other amounts owed.~~

~~(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency~~

~~department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. However, if the plan requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the plan may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. The provider shall provide the plan reasonable relevant information within 10 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the plan requires further information, the plan shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.~~

~~(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. A plan shall specify, in a written notice sent to the provider within the respective 30- or 45-working days of receipt of the claim, which, if any, of these exceptions applies to a claim.~~

~~(e) If a claim or portion thereof is contested on the basis that the plan has not received information reasonably necessary to determine payer liability for the claim or portion thereof the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of~~

~~this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt of the additional information, the plan shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor. If the plan fails to automatically include that sum or the interest due in its payment to the claimant, the plan shall pay the claimant an additional forty-five dollars ($45) penalty. The claimant may bill the plan for this additional penalty amount in addition to any other amounts owed.~~

~~(f) The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services. This section shall not be construed to prevent a plan from assigning, by a written contract, the responsibility to pay interest and late charges pursuant to this section to medical groups, independent practice associations, or other entities.~~

~~(g) A plan shall not delay payment on a claim from a physician and surgeon or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the plan's actions to resolve the claim, to the provider that submitted the claim.~~

~~(h) A health care service plan shall not request or require that a provider waive its rights pursuant to this section.~~

~~(i) This section shall not apply to capitated payments.~~

~~(j) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 in the United States on or after September 1, 1999.~~

~~(k) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 1371.~~

~~(l) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.~~

SECTION 1. Section 1348.1 is added to the Health and Safety Code, to read:

1348.1. The department shall make available to the public and providers information obtained through the process described in Section 1371.37, including, but not limited to, the following:

(a) A list of current complaints, updated monthly, with the following data for each complaint:

(1) The name of the provider submitting the complaint.

(2) The date the complaint was submitted.

(3) The name of the health care service plan or medical group having responsibility for paying the claim that is the subject of the complaint.

(4) The type of complaint.

(5) A description of actions taken, if any, by the department in reviewing, investigating, and taking enforcement action with regard to the complaint and the date each action was taken.

(b) A list of current complaints, updated monthly, categorized by the health care service plan or medical group with responsibility for paying the claim and by the type of complaint.

(c) A list of resolved or dismissed complaints, updated monthly, including the data described in subdivision (a).

SEC. 2. Section 1348.2 is added to the Health and Safety Code, to read:

1348.2. (a) The department shall develop a fast-track process for resolving a complaint regarding a payment action that it has previously found to be unfair pursuant to Section 1371.37.

(b) Within 30 days of receipt of a complaint, the department shall determine if it has previously found the payment action by the same or another health care service plan or medical group to be unfair.

(c) Notwithstanding any other provision of law, if the department has made the prior finding described in subdivision (b), it shall assess a fine against the plan or medical group in an amount that is three times the amount by which the provider was underpaid.

(d) The plan or medical group shall pay the fine to the department within 30 days of the department determination, or it may within that same timeframe, request a hearing before the director pursuant to Section 1397.

(e) One-half of the fine amount shall be retained by the department and deposited into the Managed Care Fund, and one-half of the fine amount shall be paid to the provider that submitted the complaint. The plan shall also make restitution of the underpayment as required by Section 1371.37.

SEC. 3. Section 1371.37 of the Health and Safety Code, as added by Section 6 of Chapter 827 of the Statutes of 2000, is amended to read:

1371.37. (a) A health care service plan ~~is~~ *and a medical group with responsibility to pay a provider claim are* prohibited from engaging in an unfair payment pattern, as defined in this section.

(b) *(1)* Consistent with subdivision (a) of Section 1371.39, the director may investigate a health care service plan *or a medical group* to determine whether it has engaged in an unfair payment pattern.

(2) When the number of complaints against a plan or medical group with responsibility for paying claims that were submitted by noncontracting physicians and surgeons for emergency services and care is 15 or more for a similar payment action, the department shall open an investigation. For the purposes of this paragraph, a complaint is a single payment action taken on claims submitted by noncontracting physicians and surgeons for emergency services and care.

(3) The department shall report to the budget committees of the Legislature any investigations that were not completed within six months from the date of the submission of the complaint, including an explanation of the reasons for the delay in completing the investigation and resolution of the complaint.

(4) On and after July 1, 2007, the department shall not approve, for the purpose of exempting a health care service plan or medical group from an unfair payment pattern violation, any proprietary database. For this purpose, the department shall only approve a database that is available to the public and is verified by the department as statistically credible. Prior to approving any publicly available database, the department shall

provide a 30-day notice and solicit comments from the public and interested organizations. The public notice shall include the department's analysis of the credibility of the database.

(c) An "unfair payment pattern," as used in this section, means any of the following:

(1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that results in payment delays.

(2) Engaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims.

(3) Failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Section 1371, 1371.1, or 1371.35.

(4) Failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.

(d) (1) Upon a final determination by the director that a health care service plan *or a medical group* has engaged in an unfair payment pattern, the director ~~may~~ *shall require the health care service plan or medical group to make restitution to the provider of all amounts by which it underpaid the provider. The plan or medical group shall make restitution automatically, and the provider shall not be required to resubmit a claim to the plan or medical group.*

(2) Notwithstanding paragraph (1), if the director makes a finding that an extraordinary circumstance exists, the director may require the provider to resubmit a claim, and the director shall require the plan or medical group to add to the restitution amount a reasonable amount to reimburse the provider for the costs of resubmitting the claim.

(e) (1) In addition to the remedy required by subdivision (d), the director may take any of the following actions upon his or her final determination that a health care service plan or a medical group has engaged in an unfair payment pattern:

(A) Impose monetary penalties as permitted under this chapter *in an amount that, at minimum, equals the total amount by which the provider was underpaid.*

(B) Require the health care service plan *or medical group* for a period of three years from the date of the director's determination, or for a shorter period prescribed by the director,

to pay complete and accurate claims from the provider within a shorter period of time than that required by Section 1371. The provisions of this subparagraph shall not become operative until January 1, 2002.

(C) Include a claim for costs incurred by the department in any administrative or judicial action, including investigative expenses and the cost to monitor compliance by the plan *or the medical group*.

(2) For any overpayment made by a health care service plan *or a medical group* while subject to the provisions of paragraph (1), the provider shall remain liable to the plan *or medical group* for repayment pursuant to Section 1371.1.

~~(e)~~

(f) The enforcement remedies provided in this section are not exclusive and shall not limit or preclude the use of any otherwise available criminal, civil, or administrative remedy.

~~(f)~~

(g) The penalties set forth in this section shall not preclude, suspend, affect, or impact any other duty, right, responsibility, or obligation under a statute or under a contract between a health care service plan *or a medical group* and a provider.

~~(g)~~

(h) A health care service plan may not delegate any statutory liability under this section.

~~(h)~~

(i) For the purposes of this section, "complete and accurate claim" has the same meaning as that provided in the regulations adopted by the department pursuant to subdivision (a) of Section 1371.38.

~~(i)~~

(j) On or before December 31, 2001, the department shall report to the Legislature and the Governor information regarding the development of the definition of "unjust pattern" as used in this section. This report shall include, but not be limited to, a description of the process used and a list of the parties involved in the department's development of this definition as well as recommendations for statutory adoption.

~~(j) The department shall make available upon request and on its website, information regarding actions taken pursuant to this~~

~~section, including a description of the activities that were the basis for the action.~~

SEC. 4. Section 1371.37 of the Health and Safety Code, as added by Section 6 of Chapter 825 of the Statutes of 2000, is repealed.

~~1371.37. (a) A health care service plan is prohibited from engaging in an unfair payment pattern, as defined in this section.~~

~~(b) Consistent with subdivision (a) of Section 1371.39, the director may investigate a health care service plan to determine whether it has engaged in an unfair payment pattern.~~

~~(c) An "unfair payment pattern," as used in this section, means any of the following:~~

~~(1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that results in payment delays.~~

~~(2) Engaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims.~~

~~(3) Failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Section 1371, 1371.1, or 1371.35.~~

~~(4) Failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.~~

~~(d) (1) Upon a final determination by the director that a health care service plan has engaged in an unfair payment pattern, the director may:~~

~~(A) Impose monetary penalties as permitted under this chapter.~~

~~(B) Require the health care service plan for a period of three years from the date of the director's determination, or for a shorter period prescribed by the director, to pay complete and accurate claims from the provider within a shorter period of time than that required by Section 1371. The provisions of this subparagraph shall not become operative until January 1, 2002.~~

~~(C) Include a claim for costs incurred by the department in any administrative or judicial action, including investigative expenses and the cost to monitor compliance by the plan.~~

~~(2) For any overpayment made by a health care service plan while subject to the provisions of paragraph (1), the provider~~

~~shall remain liable to the plan for repayment pursuant to Section 1371.1.~~

~~(e) The enforcement remedies provided in this section are not exclusive and shall not limit or preclude the use of any otherwise available criminal, civil, or administrative remedy.~~

~~(f) The penalties set forth in this section shall not preclude, suspend, affect, or impact any other duty, right, responsibility, or obligation under a statute or under a contract between a health care service plan and a provider.~~

~~(g) A health care service plan may not delegate any statutory liability under this section.~~

~~(h) For the purposes of this section, "complete and accurate claim" has the same meaning as that provided in the regulations adopted by the department pursuant to subdivision (a) of Section 1371.38.~~

~~(i) On or before December 31, 2001, the department shall report to the Legislature and the Governor information regarding the development of the definition of "unjust pattern" as used in this section. This report shall include, but not be limited to, a description of the process used and a list of the parties involved in the department's development of this definition as well as recommendations for statutory adoption.~~

~~(j) The department shall make available upon request and on its web site, information regarding actions taken pursuant to this section, including a description of the activities that were the basis for the action.~~

~~SEC. 2.~~

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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